File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01-005
2. STATE: CT
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
07-1-01

5. TYPE OF STATE PLAN MATERIAL (Check One):

__ NEW STATE PLAN __AMENDMENT TO BE CONSIDERED AS NEW PLAN _X_ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1924 of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY $
b. FFY $

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 2.6-A, page 4a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
Attachment 2.6-A, page 4a

10. SUBJECT OF AMENDMENT: Post-Eligibility Treatment of Income.

11. GOVERNOR'S REVIEW (Check One):

__GOVERNOR'S OFFICE REPORTED NO COMMENT
__COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
__NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
_X_ OTHER, AS SPECIFIED:
Comments, if any, to follow.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Rita M. Pacheco

13. TYPED NAME: Rita M. Pacheco

14. TITLE: Deputy Commissioner

15. DATE SUBMITTED:
June 8, 2001

16. RETURN TO:
State of Connecticut
Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033
Attention: Robert Augeri

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 12, 2001

18. DATE APPROVED: 7/10/01

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
Margaret Kemi for Ronald Preston

21. TYPED NAME:
Ronald Preston

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Citation	Condition or Requirement
1924 of the Act 435.725 435.733 435.832	2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care: Personal Needs Allowance (PNA) of not less than $30 For Individuals and $60 For Couples For All Institutionalized Persons. a. Aged, blind, disabled: Individuals $ 54.00 Couples $ 108.00 For the following persons with greater need: Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. b. AFDC related: Children $ 54.00 Adults $ 54.00 For the following persons with greater need: Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. c. Individual under age 21 covered in the plan as specified in Item B. 7. of Attachment 2.2 -A. $ 54.00